VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury, VT 05671-2306
http://www.dail.vermont.gov
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

February 15, 2013

Mr. David Silver, Administrator
Newport Health Care Center
148 Prouty Drive
Newport, VT 05855-9821

Provider #: 475026

Dear Mr. Silver:

Enclosed is a copy of your acceptable plans of correction for the re-certification survey conducted on **January 9, 2013.** Please post this document in a prominent place in your facility.

We may follow up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

PC:ne

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475026	A. BUILDING _____ B. WING _____	01/09/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEWPORT HEALTH CARE CENTER	148 PROUTY DRIVE NEWPORT, VT 05855

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F 000	INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced onsite recertification survey from 1/7/13 - 1/9/13. Regulatory violations were identified as a result.	F 000		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review, resident interviews, and staff interview the facility failed to assure that the activities program provided met the interests of 2 of 2 residents (Residents #53 & #30) reviewed in the Stage 2 sample. Findings include: 1. The Activities Director (AD) stated in interview on 1/9/13 at 9:01 AM that s/he is not a certified activity specialist but was an LNA (Licensed Nursing Assistant). S/he states that s/he has had no training in providing activities to the Long Term Care population, elderly, or residents with dementia, but that s/he does on-line research for activity ideas and information. A review of activity schedules reveals no activities on Sundays or after 2:00 PM on any day. S/he states that Sunday activities were discontinued due to poor attendance. There is an activity person on Saturday and daytime activities are	F 248	See attached plan of correction pg. 1	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Administrator	02/04/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 248	Continued From page 1 offered. The activities department does no evening activities and does not plan for any evening activities by the staff according to the AD. There are books and magazines available for residents who want them. The AD states that she also gives evening activities such as puzzles and books to residents who request them. 2. Per interview with Resident #53 during the Stage 1 resident interview, s/he does not attend activities and the facility activities don't interest her. S/he states that s/he has reading materials and watches TV. Per record review, Resident #53 has an activity history but no activity assessment in the record. The resident's admission MDS (Comprehensive Assessment) is not completed per interview with the MDS nurse on 1/9/13 at 12:50 PM. Activity attendance sheets reflect that the resident had family visitors on some days but not that activities or 1:1 activities were offered and refused. 3. Per interview with Resident #30 on 1/7/2013 at 3:28 PM s/he stated that there is no interest in the facility activities and there is a preference not to attend "fake" bowling or big parties, but rather to watch DVDs. Resident #30 also indicated that s/he likes to cook and doesn't like to be around people s/he doesn't know and that are older than her/him. Per record review on 1/8/2013 Resident #30 had an Admission MDS dated 6/28/2012 and section F0400 indicated that the resident prefers to take walks and read newspapers. The resident confirmed that this was a preference and that	F 248		

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F 248	Continued From page 2 s/he doesn't get asked if s/he would like the newspaper. Her/His admission activity assessment also indicates that the resident prefers to do individual activities. Per interview with the Activities Director (AD) on 1/9/2013 at 9:01 AM s/he stated that input is gathered from the residents as to what they would like to do. S/he also stated that if a resident declines all offers, the family is asked to assist with ideas. S/he stated that Resident #30 does one to one activities and does not like to participate and is a very private person and refuses to participate. S/he also indicated that cooking and baking is not a regular part of the activity program. Review of attendance sheets on 1/9/2013, provided by the AD, during the time frame of 11/12/2012 and 1/04/2013 does not indicate that the resident is encouraged to participate in activities 27 out of 51 days.	F 248		
F 273 SS=D	483.20(b)(2)(i) COMPREHENSIVE ASSESSMENT 14 DAYS AFTER ADMIT A facility must conduct a comprehensive assessment of a resident within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or for therapeutic leave.) This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the	F 273	**See attached plan of correction pg. 1**	

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F 273	Continued From page 3 facility failed to assure that a comprehensive admission assessment was completed within 14 calendar days after admission for 1 resident (Resident # 53) in the Stage 2 Sample of 23. Findings include: Per record review on 01/09/2013 at 10 AM, Resident #53 was admitted on Dec 13, 2012. In a review of the resident's record there is no Minimum Data Set (MDS) in the record. In an interview on 01/09/2013 at 11:45 AM, the MDS nurse confirmed that an admission MDS had not been completed for Resident #53 who has been in the facility for 27 days.	F 273		
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279	**See attached plan of correction pg. 1 & 2**	

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F 279	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to develop care plans based on the comprehensive assessments and individual needs for 8 of 23 residents (#34, 30, 25, 53, 52, 51,15 and 46). The findings are: 1. Per medical record review on 01/08/2013 at 1:38 PM, there is no care plan to address the nutritional needs of Resident #51, who is documented to have lost 8 pounds since admission to the facility on 11/01/2012. A Dietician note dated 11/09/2012 indicates that this resident "would benefit from health shakes twice daily given weight loss, and encouragement to eat." The Director of Nursing (DNS) confirms during interview at 11:44 am on 01/09/2013 that there is no nutrition care plan for Resident #51. The DNS further reports that unless the dietician spoke with direct care staff there is no facility policy for communicating that the shakes that were recommended by the dietician are actually given. 2. Per medical record reviewed on 01/8/2013 at 12:15 PM, there is no care plan developed for Resident #15 addressing the use of psychotropic medications. The DNS confirms during interview on 01/08/2013 at 1:25 PM no care plan for the use of psychotropic medications has been developed for Resident #15. 3. Per medical record review on 01/09/2013 at 9:00 AM, there is no development of an interim	F 279		

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F 279	Continued From page 5 care plan that addresses the needs for Resident #52, who was admitted on 01/04/2013 for care after open heart surgery. The DNS confirms during interview on 01/09/2013 at 11:20 AM that there is no written interim care plan for Resident #52, and that specifics to his/her care were communicated to staff during shift reports. There is a care plan meeting scheduled for the afternoon of 01/09/2013 and the DNS reports that s/he was waiting for that meeting to formulate a written care plan. 4. Per record review on 1/8/13, the medical record of Resident #46 (1 of 1 residents in the hospice/palliative care sample) contained no evidence that the facility had developed a written plan of care with specific goals and strategies for the provision of comfort care measures. A telephone order taken by a Registered Nurse from the primary physician on 12/27/12 designated "keep comfortable". During an interview on 1/8/13 at 2:00 PM, the Director of Nursing Services (DNS) confirmed that the medical record showed no evidence that a written plan of care to direct staff in specific comfort care measures had been developed for Resident #46. 5. Per record review and staff interviews, Resident #53 is receiving Dialysis. In a review of the resident record, the Care Plan contains a section for Renal Failure which contains only minimal information, i.e. the days that the resident has dialysis, but does not contain other information. In a review of the care plan there is not information on dialysis center protocols and communication with the center, access	F 279		

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F 279	Continued From page 6 maintenance and monitoring, medication, nutrition and fluid balance issues, and/or pre and post dialysis care. The Director of Nursing confirmed the above information in an interview at 2:35 PM on 1/8/13. 6. Per record review and staff interviews, Resident #25 is listed in the most recent MDS (Comprehensive Assessment), dated 10/10/12, as having Impaired Vision and No Corrective Lenses. The Admission assessment dated 7/26/10 stated that the resident has impaired vision and wears glasses for reading. During observations in Stage 1 of the survey the resident was not observed wearing glasses. In an interview on 1/8/13 at 3:30 PM, the unit nurse stated that the resident does not wear glasses because he refuses to allow staff to put them on and that he had actually broken his glasses which were not replaced due to his refusal to wear them and the fact that he does not read any longer due to his advanced Dementia. In a review of the record there is no information in the plan of care regarding the resident's use of glasses or the reasons he no longer uses his glasses. This information was confirmed by both the Unit Manager and the Director of Nurses on 1/9/13 at 10:55 AM. 7. Per record review on 1/8/2013 at 12:45 PM, there was no care plan in place to address needs pertaining to vision impairment for Resident #34. Resident #34 was admitted on 10/28/2011. Per assessment data from the Minimum Data Sets (MDS) completed on 11/09/2011, Resident #34 was initially assessed as having impaired vision. Subsequent MDS assessments completed on 02/07/2012 and 05/07/2012 denote a higher level	F 279		

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F 279	Continued From page 7 of visual impairment and coded as "moderately impaired." The final MDS assessment on 10/24/2012 denotes the visual impairment to have further deteriorated and coded as "highly impaired." Nursing notes dated 08/30/2012 reveal Resident #34 having difficulty with eyesight related to a recent dilation intervention. Nursing notes dated 10/21/2012 reveal Resident #34 having highly impaired vision related to cataracts. MD consultation notes dated 09/14/2012 indicate Resident #34 can barely discern hand movement. MD note dated 11/09/2012 indicate Resident #34 is afraid to have corrective surgery for bilateral cataracts. Per interview of the charge nurse on 01/08/2013 at 1:00 PM, the charge nurse verbally confirmed the lack of a care plan for Resident #34 in respect to visual impairment. The charge nurse verbalized that the care plan was not in place and that there should have been one in place. 8. Per record review for Resident #30 on 1/8/2013, Activity notes dated 10/9/2012 indicate that the resident mostly refuses participation in group activity programs and stays in room and will participate only in her/his room with one-to-one initiate. An interim care plan dated 6/28/2012 did not include activities and no revision of this care plan had been made at the time of the record review. Per interview on 1/8/2013 at 3:35 PM the LPN on duty confirmed that there was no care plan for Resident #30 and if the care plans were not in the care plan notebook or the chart s/he did not know where to	F 279		

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F 279	Continued From page 8 find them. The LPN charge nurse confirmed, after looking for the activity care plan for Resident #30, that there was not one. Per interview with the Activity Director (AD) on 1/9/2013 at 9:00AM s/he stated that they do the activity care plans and that they are done on every resident within a week to a week and a half after admission. During this interview s/he also stated that the activity care plan is updated quarterly. When request was made for a copy of the activity comprehensive care plan the AD presented an admission activity assessment instead of a care plan and stated that is the only thing s/he does for a care plan. An interview with Social Service on 1/9/2013 at 9:30 AM indicated that s/he coordinates the care plan meetings, but does not do the actual care plans and they are done by the Director of Nursing (DON). Per interview with the DON on 1/9/2013 at10:55AM s/he indicated that s/he does not do an activity care plan for the residents and she was unable to locate one when s/he looked in the care plan book and chart and confirmed that there there was no activity care plan for Resident #30 and that there should be an activity care plan for all residents.	F 279		
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed	F 280	**See attached plan of correction pg. 2**	

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F 280	Continued From page 9 within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to revise the care plans for 4 of 23 residents reviewed in the stage 2 sample (Resident #15, 17, 42, 46). Findings include: 1. Per record review on 1/9/13 at 8:00 AM, the care plan for Resident #17 was not revised to reflect 2 falls. Per review of nursing notes, Resident #17 fell on 12/7/12 and again on 12/24/12. During an interview with the Director Of Nursing (DNS) on 1/9/13 at 8:15 AM, the DNS confirmed that the care plan for Resident # 17 should have been revised and was not revised after the 2 falls in December 2012. 2 Per medical record review on 01/09/2013 at 11:58 AM, Resident #42, who was admitted on 10/27/2010 with memory disturbance, dementia, ataxia and dizziness and other comorbities, did	F 280		

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F 280	Continued From page 10 not have an updated care plan to reflect falls of 01/05/2013 or 01/08/2013. The most recent falls risk assessment is dated 10/10/2012 and codes Resident #42 as a 20 or "High Risk." There is a care plan to reflect falls risk dated 10/18/2011 but it has not been updated or revised. The Director of Nursing (DNS) confirms during interview on 01/08/2013 at 1:25 PM that there is no updated care plan to address the current falls or additional interventions that may be needed for Resident #42. 3. Per medical record reviewed on 01/8/2013 at 12:15 PM, an Interdisciplinary care plan lists falls risk as a problem related to unsteady gait and psychotropic medications for Resident #15. The care plan states: "Nursing staff will administer Ativan...and Seroquel...as ordered by MD. Staff will monitor side effects of Ativan and Seroquel daily." Ativan has been discontinued since May 2012. The care plan has not been revised and there are no specific behaviors for staff to monitor other then the above statement about side effects. The DNS confirms during interview on 01/08/2013 at 1:25 PM that there is no care plan for psychotropic medications for Resident #15 and that the falls risk care plan has not been revised to reflect the discontinuation of Ativan in May 2012. 4. Per record review on 1/8/13, the facility failed to revise the written plan of care for Resident #46 to reflect his/her current and specific nursing care needs. The Standing Orders, signed by the primary physician on 8/24/12, indicated that staff should not use a urinary catheter due to a urethral (bladder tube) blockage. The current written plan of care includes instructions to staff to change the	F 280		

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F 280	Continued From page 11 [Foley] catheter bag weekly on Sundays. Additionally, the primary physician ordered on 11/23/12 a discontinuation of Coumadin (an anticoagulant medication) and the blood tests which check clotting time related to the Coumadin therapy (PT/INR). The current care plan contains a section with multiple specific instructions related to Coumadin therapy. On 12/14/12, the physician ordered the discontinuation of Fiber source feedings (a liquid dietary supplement) which had been given through the gastric (stomach) tube. The written current care plan contains directives related to Fiber source and the care of the feeding syringe and bag. Additionally, the physician ordered on 12/27/12 that Resident #46 receive comfort care measures. The written plan of care does not include any specific goals and strategies to direct the staff in providing the comfort care measures. During an interview on 1/8/13 at 2:00 PM, the Director of Nursing Services (DNS) confirmed that the written plan of care for Resident #46 does reflect his/her current status or nursing care needs, and that it lacks specific revisions regarding use of a catheter, anticoagulant therapy, tube feedings, and comfort care.	F 280		
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced	F 281	See attached plan of correction pg. 3	

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F 281	Continued From page 12 by: Based on staff interview and record review the facility failed to ensure services provided met professional standards of quality for 6 of 23 residents in the stage 2 sample regarding Licensed Practical Nurse scope of practice (Residents #52, 55, 15, 46, 35, 54). Findings include: 1. Per record review on 1/8/13 at 8:59 AM, Resident #35 was pronounced dead by a Licensed Practical Nurse (LPN). Resident #35 was admitted with physician orders do not intubate, do not resuscitate and do not transfer. A nursing progress note by an LPN on 8/11/12 stated that the resident was found with no pulse or respirations and had expired. There is no evidence in the clinical record that a physician had gave an order for a licensed practical nurse to pronounce death. There was no evidence that a Registered Nurse (RN) or a physician had assessed the resident to confirm death. During a 9:12 AM interview on 1/8/13, the Director of Nurses (DNS) stated that it is his/her expectation that an RN pronounce death, not an LPN. The DNS confirmed that the facility had no policy regarding who may pronounce death. During a 12:00 PM interview on 1/8/12, the DNS confirmed that an LPN had pronounced Resident #35 as dead and that neither an RN or a physician had assessed the resident. 2. Per record review on 1/8/13 at 1:50 PM, Resident #54 who was admitted on 11/28/12 for palliative care was pronounced dead by an LPN. A nursing note by an LPN on 12/3/12 at 1:15 AM stated that respirations had ceased at 0115, no	F 281		

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	475026	A. BUILDING _____ B. WING _____	01/09/2013

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NEWPORT HEALTH CARE CENTER	148 PROUTY DRIVE NEWPORT, VT 05855

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F 281	Continued From page 13 pulse. During interview on 1/8/13 at 2:00 PM the DNS confirmed lack of a physician order for nurse pronouncement and that an LPN pronounced Resident #54 dead. 3. Per record review on 1/8/13 at 1:22 PM, Resident #55 who was admitted on 10/24/12 was pronounced dead by an LPN. Per a nursing note 11/29/12 3-11 shift by an LPN, Resident #55 expired at 1900, no heartbeat or respirations. There were no physician orders for a nurse to pronounce and no evidence that a physician or an RN assessed the resident. On 1/8/13 at 1:49 PM the DNS confirmed there was no physician order to pronounce, that an LPN pronounced resident #55 as dead and that neither an RN or a physician had assessed the resident. 4. Per medical record review on 01/09/2013 at 9:00 AM, Resident #52, who was admitted on 01/04/2013 for after care of cardiac surgery had an initial assessment that was done and signed by an LPN and not an RN. The DNS confirmed during interview on 01/09/2013 at 11:20 AM that an LPN did do and sign the initial assessment and that it was not reviewed by an RN. 5. Per medical record review on 01/08/2013 at 12:15 PM, Resident #15 was admitted on 03/19/2012. The initial assessment was done and signed by an LPN and not an RN. The DNS confirms during interview on 01/08/2013 that the initial assessment for Resident # 15 was performed by an LPN and not reviewed by an RN.	F 281		

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F 281	Continued From page 14 6. Per record review on 1/9/13, the Admission Nursing Assessment for Resident #46, dated 11/13/12, does not contain a signature or date in the designated space. The Fall Risk and Pressure Ulcer Risk Assessments are each signed by a Licensed Practical Nurse (LPN). The nurse note of 11/13/12 at 1800 (6:00 PM) which corresponds to the admission assessment is written and signed by the LPN. There is no evidence in the medical record to indicate that a Registered Nurse (RN) either conducted, coordinated or signed the comprehensive admission assessment for Resident #46 to certify its completion. On 1/9/13 at 8:20 AM, the Director of Nursing Services (DNS) confirmed that the admission assessment documents for Resident #46 were completed by an LPN, and that there is no evidence of review or signature by an RN to certify its completion. Reference: Vermont State Board of Nursing. Determining Scope of Practice, Position Statement and Decision Tree. http://vtprofessionals.org/opr1/nurses/position_statements/PS-Determining%20Scope%20of%20Practice%20plus%20Decision%20Tree.pdf. Accessed January 23, 2013. The Vermont Statutes Online. Title 26: Professions and Occupations. Chapter 28: Nursing. http://www.leg.state.vt.us/statutes/fullchapter.cfm?Title=26&Chapter=028. Accessed January 23, 2013.	F 281		

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F 281	Continued From page 15 Vermont State Board of Nursing. Role of the Registered Nurse in the Pronouncement of Death, Position Statement. http://vtprofessionals.org/opr1/nurses/position_statements/PS-Role%20of%20the%20RN%20in%20the%20Pronouncement%20of%20Death.pdf. Accessed January 23, 2013.	F 281		
F 282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to implement the care plan for 1 of 23 residents in the Stage 2 sample (Resident #46). Findings include: 1. Based on record reviews and interviews, the facility failed to assure that Resident #46 received nutritional supplements ("health shakes") three times per day, as recommended and care planned by the Registered Dietician (RD). In order to address conditions of malnutrition, weight loss, and poor oral intake, Resident #46 received daily feedings through a stomach tube from admission on 11/13/12 until this was discontinued by the physician on 12/14/12. The Nutrition Plan of Care and the RD notes of 1/3/13 specifically indicate that the health shakes should be provided three times per day, in addition to encouraging meals and snacks. Review of the flow sheets where staff record meal intake by	F 282	**See attached plan of correction pg. 3**	

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F 282	Continued From page 16 indicating % consumed (including 1/3-1/8/13), there is no evidence to indicate whether Resident #46 drank the health shakes or any portion of them. In an interview on 1/9/13 at 8:20 AM, the Director of Nursing Services (DNS) confirmed that the health shakes come from the kitchen on the meal tray three times per day, and that staff do not record the % of nutrition supplements consumed on the meal intake form.	F 282		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to assure 1 of 3 applicable residents (Resident #17) of the 23 residents sampled in stage 2 received adequate supervision and assistance to prevent accidents. Findings include: 1. Per record review on 1/9/13 at 8:00 AM, Resident #17 was not comprehensively assessed after falling. Per review of the Minimum Data Set (MDS) dated 10/24/12, Resident #17 has impaired vision and has daily behavioral issues, including delusions and hallucinations. The Resident's balance is described as unsteady when turning around. Per review of nursing notes, Resident #17 fell on 12/7/12 and 12/24/12. A falls	F 323	**See attached plan of correction pg. 3**	

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F 323	Continued From page 17 risk assessment was not done after either fall. There was no written facility policy or procedures that specifically addressed falls. A floor nurse interviewed on 1/9/13 was unaware of a written falls policy or procedure. On 1/19/13 at 8:15 AM, the Director of Nursing (DNS) confirmed that there was no policy or procedure that specifically addressed falls. The DNS also confirmed that staff did not perform a falls risk assessment after a fall but stated "they probably should".	F 323		
F 354 SS=F	483.30(b) WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to use the services of a Registered Nurse for at least 8 consecutive hours a day, 7 days a week. Findings include: Per review of facility actual staffing documents on 1/8/13 at 2:50 PM, the facility did not have a Registered Nurse (RN) on site for 8 consecutive	F 354	**See attached plan of correction pg. 3**	

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F 354	Continued From page 18 hours on 10 days between 8/6/12 and 1/6/13. The Director of Nursing (DNS) confirmed the above during interview on 1/8/13 at 3:32 PM	F 354		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to assure that food was prepared and dishes and utensils were cleaned under sanitary conditions. Findings include: 1. Per staff interview with the Dietary Manager on 1/7/13 at 10:30 AM, the facility uses both high dishwasher temperatures and chlorine sanitizer to assure the dishes are sanitized. S/he stated that the rinse temperatures should be at 160 degrees Fahrenheit according to information he was told by the Administrator. In review of the records, dishwasher wash temperatures were consistently above 120 degrees Fahrenheit (F) in December 2012 and January 2013 to date. Dishwasher rinse temperatures were between 139-165 degrees F as recorded in December 2012. Dishwasher temperatures were not consistently	F 371	**See attached plan of correction pg. 3**	

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F 371	Continued From page 19 monitored in December 2012 and January 2013. The Chlorine sanitizer levels for December 2012 and January 2013 were not consistently recorded. In an interview at 11:20 AM on 1/7/13 the Food Services Director stated that facility practice was that the person washing dishes checks the dishwasher temperatures and chlorine levels twice a day at 8 AM and 2 PM. S/he further stated that he was not aware of the missing documentation of the temperatures and that they "check the chlorine" but that they don't always record it. The Dietary Manager stated that s/he had requested a copy of written information regarding proper temperature parameters from the Administrator and that there is no written information available. In an interview at 11:45 AM on 1/7/13 the person washing dishes stated that s/he checks the temperatures and chlorine levels and that s/he is not sure what to do if the numbers are out of range. When asked what the levels for temperature and chlorine should be s/he stated that s/he isn't sure what the readings should be. In an interview at 11:45 AM the Dietary Manager stated that s/he doesn't know what the procedure is if the numbers are out of range. In interview at 3:15 PM the Administrator confirmed that there was no written information regarding acceptable parameters for temperatures and chlorine levels available and that his understanding is that the dishwasher rinse temperature should be 160 degrees F. S/he further stated that there are no written policies and procedures regarding these dishwasher temperatures or chlorine levels. 2. In the initial tour of the kitchen on 1/7/13, three vents on the front of the range hood and one	F 371		

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F 371	Continued From page 20 ceiling vent over the food cooking/preparation area were noted to be coated with grease and dust. The finding was confirmed with the Food Services Director on 1/7/12 at 11:40 AM.	F 371		
F 492 SS=E	483.75(b) COMPLY WITH FEDERAL/STATE/LOCAL LAWS/PROF STD The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility regarding scope of Licensed Practical Nurse (LPN)practice. Findings include: 1. Per record review on 1/8/13 at 8:59 AM, Resident #35 was pronounced dead by a Licensed Practical Nurse (LPN). Resident #35 was admitted with physician orders do not intubate, do not resuscitate and do not transfer. A nursing progress note by an LPN on 8/11/12 stated that the resident was found with no pulse or respirations and had expired. There is no evidence in the clinical record that a physician had gave an order for a nurse to pronounce death. There was no evidence that a Registered	F 492	**See attached plan of correction pg. 4**	

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F 492	Continued From page 21 Nurse (RN) or a physician had assessed the resident to confirm death. During a 9:12 AM interview on 1/8/13, the Director of Nurses (DNS) stated that it is his/her expectation that an RN pronounce death, not an LPN. The DNS confirmed that the facility had no policy regarding who may pronounce death. During a 12:00 PM interview on 1/8/12, the DNS confirmed that an LPN had pronounced Resident #35 as dead and that neither an RN or a physician had assessed the resident. 2. Per record review on 1/8/13 at 1:50 PM, Resident #54 who was admitted on 11/28/12 for palliative care was pronounced dead by an LPN. A nursing note by an LPN on 12/3/12 at 1:15 AM stated that respirations had ceased at 0115, no pulse. During interview on 1/8/13 at 2:00 PM the DNS confirmed lack of a physician order for nurse pronouncement and that an LPN pronounced Resident #54 dead. 3. Per record review on 1/8/13 at 1:22 PM, Resident #55 who was admitted on 10/24/12 was pronounced dead by an LPN. Per a nursing note 11/29/12 3-11 shift by an LPN, Resident #55 expired at 1900, no heartbeat or respirations. There were no physician orders for a nurse to pronounce and no evidence that a physician or an RN assessed the resident. On 1/8/13 at 1:49 PM the DNS confirmed there was no physician order to pronounce, that an LPN pronounced Resident #55 as dead and that neither an RN or a physician had assessed the resident. 4. Per medical record review on 01/09/2013 at 9:00 AM, Resident #52, who was admitted on	F 492		

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F 492	Continued From page 22 01/04/2013 for after care of cardiac surgery had an initial assessment that was done and signed by an LPN and not an RN. The DNS confirmed during interview on 01/09/2013 at 11:20 AM that an LPN did do and sign the initial assessment and that it was not reviewed by an RN. 5. Per medical record review on 01/08/2013 at 12:15 PM, Resident #15 was admitted on 03/19/2012. The initial assessment was done and signed by an LPN and not an RN. The DNS confirms during interview on 01/08/2013 that the initial assessment for Resident #15 was performed by an LPN and not reviewed by an RN. 6. Per record review and staff interviews, the facility failed to assure that the admission assessment for Resident #46 was conducted or coordinated and signed to certify completion by a qualified professional (registered nurse). Per record review on 1/9/13, the Admission Nursing Assessment for Resident #46, dated 11/13/12, does not contain a signature or date in the designated space. The Fall Risk and Pressure Ulcer Risk Assessments are each signed by a Licensed Practical Nurse (LPN). The nurse note of 11/13/12 at 1800 (6:00 PM) which corresponds to the admission assessment is written and signed by the LPN. There is no evidence in the medical record to indicate that a Registered Nurse (RN) conducted, coordinated or signed to certify completion of the comprehensive admission assessment documents for Resident #46. On 1/9/13 at 8:20 AM, the Director of Nursing Services (DNS) confirmed that the admission assessment documents for Resident #46 were completed by an LPN, and that there is	F 492		

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F 492	Continued From page 23 no evidence of review or signature by an RN to certify completion. References: Vermont State Board of Nursing. Determining Scope of Practice, Position Statement and Decision Tree. http://vtprofessionals.org/opr1/nurses/position_statements/PS-Determining%20Scope%20of%20Practice%20plus%20Decision%20Tree.pdf. Accessed January 23, 2013. The Vermont Statutes Online. Title 26: Professions and Occupations. Chapter 28: Nursing. http://www.leg.state.vt.us/statutes/fullchapter.cfm?Title=26&Chapter=028. Accessed January 23, 2013. Vermont State Board of Nursing. Role of the Registered Nurse in the Pronouncement of Death, Position Statement. http://vtprofessionals.org/opr1/nurses/position_statements/PS-Role%20of%20the%20RN%20in%20the%20Pronouncement%20of%20Death.pdf. Accessed January 23, 2013.	F 492		
F9999 SS=E	FINAL OBSERVATIONS Per Vermont Licensing and Operating Rules for Nursing Homes regulation 5.3 (b) Accuracy of Assessments: Each assessment must be conducted or coordinated by a registered nurse who signs and certifies the completion of the assessment. Based on record reviews and interviews, the facility failed to assure that the assessments for 6	F9999	**See attached plan of correction pg. 4**	

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F9999	Continued From page 24 of 23 residents in the sample (Residents #52, 55, 15, 46, 35, 54) were conducted or coordinated by a Registered Nurse who signs and certifies the completion of the assessment. Findings include: 1. Per record review on 1/8/13 at 8:59 AM, Resident # 35 was pronounced dead by a Licensed Practical Nurse (LPN). Resident #35 was admitted with physician orders do not intubate, do not resuscitate and do not transfer. A nursing progress note by an LPN on 8/11/12 stated that the resident was found with no pulse or respirations and had expired. There is no evidence in the clinical record that a physician had gave an order for a nurse to pronounce death. There was no evidence that a Registered Nurse (RN) or a physician had assessed the resident to confirm death. During a 9:12 AM interview on 1/8/13, the Director of Nurses (DNS) stated that it is his/her expectation that an RN pronounce death, not an LPN. The DNS confirmed that the facility had no policy regarding who may pronounce death. During a 12:00 PM interview on 1/8/12, the DNS confirmed that an LPN had pronounced Resident # 35 as dead and that neither an RN or a physician had assessed the resident. 2. Per record review on 1/8/13 at 1:50 PM, Resident # 54 who was admitted on 11/28/12 for palliative care was pronounced dead by an LPN. A nursing note by an LPN on 12/3/12 at 1:15 AM stated that respirations had ceased at 0115, no pulse. During interview on 1/8/13 at 2:00 PM the DNS confirmed lack of a physician order for nurse pronouncement and that an LPN pronounced Resident # 54 dead.	F9999		

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F9999	Continued From page 25	F9999		

3. Per record review on 1/8/13 at 1:22 PM, Resident # 55 who was admitted on 10/24/12 was pronounced dead by an LPN. Per a nursing note 11/29/12 3-11 shift by an LPN; Resident # 55 expired at 1900, no heartbeat or respirations. There were no physician orders for a nurse to pronounce and no evidence that a physician or an RN assessed the resident. On 1/8/13 at 1:49 PM the DNS confirmed there was no physician order to pronounce, that an LPN pronounced resident # 55 as dead and that neither an RN or a physician had assessed the resident.

4. Per medical record review on 01/09/2013 at 9:00 AM, Resident #52, who was admitted on 01/04/2013 for after care of cardiac surgery had an initial assessment that was done and signed by an LPN and not an RN. The DNS confirmed during interview on 01/09/2013 at 11:20 AM that an LPN did do and sign the initial assessment and that it was not reviewed by an RN.

5. Per medical record review on 01/08/2013 at 12:15 PM, Resident #15 was admitted on 03/19/2012. The initial assessment was done and signed by an LPN and not an RN. The DNS confirms during interview on 01/08/2013 that the initial assessment for Resident #15 was performed by an LPN and not reviewed by an RN.

6. Per record review and staff interviews, the facility failed to assure that the admission assessment for Resident #46 was conducted or coordinated and signed to certify completion by a qualified professional (registered nurse). Per record review on 1/9/13, the Admission Nursing Assessment for Resident #46, dated 11/13/12,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475026	A. BUILDING _____ B. WING _____	01/09/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEWPORT HEALTH CARE CENTER	148 PROUTY DRIVE NEWPORT, VT 05855

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 26 does not contain a signature or date in the designated space. The Fall Risk and Pressure Ulcer Risk Assessments are each signed by a Licensed Practical Nurse (LPN). The nurse note of 11/13/12 at 1800 (6:00 PM) which corresponds to the admission assessment is written and signed by the LPN. There is no evidence in the medical record to indicate that a Registered Nurse (RN) conducted, coordinated or signed to certify completion of the comprehensive admission assessment documents for Resident #46. On 1/9/13 at 8:20 AM, the Director of Nursing Services (DNS) confirmed that the admission assessment documents for Resident #46 were completed by an LPN, and that there is no evidence of review or signature by an RN to certify completion. Per Vermont Licensing and Operating Rules for Nursing Homes regulation 7.13 (c) (1) Nursing Services, Registered Nurse: The facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. Based on staff interview and record review the facility failed to use the services of a Registered Nurse for at least 8 consecutive hours a day, 7 days a week. Findings include: Per review of facility actual staffing documents on 1/8/13 at 2:50 PM, the facility did not have a Registered Nurse (RN) on site for 8 consecutive hours on 10 days between 8/6/12 and 1/6/13. The Director of Nursing (DNS) confirmed the above during interview on 1/8/13 at 3:32 PM	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475026	A. BUILDING _____ B. WING _____	01/09/2013

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NEWPORT HEALTH CARE CENTER	148 PROUTY DRIVE NEWPORT, VT 05855

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F248, F273, F279, F280, F281, F282, F323, F354, F371, F492, + F9999
Plans of correction accepted 2/12/13
RTremblay RN | PMC

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F 248 The activity schedule has been reviewed and updated to include more activities especially after 2 pm and on Sundays. Also alternate activities have been revised and will be offered to residents that refuse to attend activities. Completed on 1/30/13.

Resident # 53 activity assessment has been completed and placed in the record. The admission MDS has been completed. Activity attendance sheets have been Revised to include activities offered and refused. Completed on 2/1/13.

Resident #30 will be interviewed regarding likes and dislikes for activities. More of a variety of activities will be offered as evidenced by the updated schedule. Newspapers will be offered to resident. Activity attendance sheets will document activities offered and refused. Completed on 1/18/13.

All residents will have their activity assessments reviewed and revised. This will be completed by 2/9/13.

The activity assessments will be reviewed at care plan meetings at least quarterly.

The Activities Director will have the above completed by 2/9/13.

F 273 All residents will have a comprehensive admission completed within 14 calendar days. MDS will be completed within the 14 days.

Resident #53 has had the MDS completed on 1/10/13.

The DON will monitor on a weekly basis whenever there is a new admission. All residents' charts will be checked for completion.

F 279 Care plans will be reviewed and updated on all residents.
They will include dietary, antipsychotic medications, vision as well as comfort/palliative care. Healthy shakes will be included on the care plans, physicians orders and will be documented on the treatment sheets with information as to whether it was accepted and amount consumed.
Interim care plans will be done within 24 hours after admission. Complete care plans will be done within the 14-day requirement.
DON will review and update all care plans. Care plans will be reviewed at care plan conferences at least quarterly. DON will monitor them at least weekly for Any changes in status or new orders. The nurse taking the orders will also update the care plans. All care plans will have been updated by 2/9/13.

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Resident #53 care plan has been revised and updated to include all protocols from dialysis center and communication with the center. DON will review and update care plan after every dialysis appointment to monitor for changes. This will be completed by 2/1/13.

Resident #25 and #34 will have their vision assessment included in the care plan. This will be completed by 2/1/13.

Resident # 30 will have activity care plan reviewed and completed by 2/9/13.

All residents will have activity care plans by 2/9/13.

All aspects of care plans to include social service, activities, dietary and nursing will be reviewed at scheduled care conferences at least quarterly and whenever there are any changes in status or orders.

F 280 Care plans will be developed within 7 days after the completion of the comprehensive assessment.
The DON will monitor this after all admissions and at least quarterly during care Conferences and whenever there are changes in status or orders.

Care plans will have all falls documented on the plan as well as a fall risk assessments to be done after each fall.

Resident #17 and #42 will have care plan revised with falls, updated risk assessments done interventions needed by 2/1/13.

Resident #15 with have care plan updated regarding meds that have been discontinued and specific behaviors to monitor by 2/1/13.

Resident #46 will have care plan updated regarding her urinary catheter order, tube feedings and coumadin/lab work by 2/1/13.

DON will monitor all care plans at least weekly.

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F281 The Vermont State Board of Nursing position on pronouncement of death was reviewed. A new procedure/policy has be initiated to reflect that an RN is the only one to pronounce death with a physician order. Whenever comfort care or palliative care is ordered; an order for RN pronouncement will be obtained from the physician as part of the order. The physician will be notified at the time of death.

This will be monitored by the DON. An in-service with all nursing staff has been completed to review this policy/procedure. This was completed on 1/15/13.

All assessments will be reviewed and signed by an RN including fall risk and pressure ulcer assessments. An in-service with all nursing staff will be held. This will be completed by 2/9/13.

F 282 Health shakes will be monitored on flow sheets to document whether resident has consumed shake and how much. They will also be included on the treatment sheets. This will be completed by 2/9/13. DON will monitor at least monthly.

F 323 Fall risk assessments will be done after all falls. Residents will be monitored for head injuries after falls. This will especially be important with dementia patients.
A new policy/procedure is being initiated for this and will be completed by 2/9/13.
DON will monitor every fall to assure this is being done.

F 354 A registered nurse will be scheduled for at least 8 hours per day/7 days a week. DON will monitor schedule when posted to make sure this is achieved. This was completed on 1/8/13.

F 371 New forms were initiated to document the temperature and chlorine sanitizer for the dishwasher. This will be checked three times a day at breakfast, lunch and dinner. White River Paper forwarded a data sheet with the range of temperatures to be in compliance. This was completed on 1/8/13.
Dietary Supervisor will monitor daily to assure it is being done.

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F 492 A policy/procedure will be initiated indicating that an RN not an LPN can pronounce death following an order from the physician. This will be completed by 2/9/13.

A policy/procedure will be initiated indicating that an RN will review and sign all assessments. This will be completed by 2/9/13.

DON will monitor each death and each assessment as indicated.

F9999 A policy/procedure will be initiated indicating that an RN not an LPN can pronounce death following an order from the physician. This will be completed by 2/9/13.

A policy/procedure will be initiated indicating that an RN will review and sign all assessments. This will be completed by 2/9/13.

DON will monitor each death and each assessment as indicated.

A registered nurse will be scheduled for at least 8 hours per day/7 days a week. DON will monitor schedule when posted to make sure this is achieved. This was completed on 1/8/13.